State Police Officers Council
Health Benefit Summary
Effective July 1, 2010

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

Plan Provisions	Alliance Select
Lifetime Benefits Maximum – The maximum amount each covered family member is eligible to receive under this plan for covered services in his or her lifetime.	Unlimited
Lifetime Maximum on Infertility Services	$15,000; Coinsurance does not apply to OPM.
Out-of-Pocket Expenses – The amount you pay for certain covered services. There are two types of out-of-pocket expenses: 1) Deductible - a fixed amount you pay for certain services before Wellmark makes benefit payments. 2) Coinsurance - a fixed percentage you pay for certain services.	See below for your specific out-of-pocket amounts.
Out-of-Pocket Maximum (OPM) – The maximum amount you pay for covered services in a calendar year. Once your OPM is satisfied, most services are covered in full through the end of the calendar year.	Single $750 Family $1,500
Health Plan Basics	**Alliance Select**
Benefit Period Deductible - Applies to **ALL** Services except Well Child Care	Single $250 Family $500
Coverage for Care Provided Outside of Iowa	BlueCard® PPO Program benefits apply.
Precertification	Inpatient admission, home health and hospice Out-of-Network - Member's responsibility to precertify 50% penalty for failure to precertify. In-Network - Select provider performs
Waiting Period	None except for late enrollees, then 18 months.
Dependent Child Age Limit	• A dependent child through their 26th year. • A full-time student in an accredited institution of postsecondary education regardless of age. • Totally and permanently disabled, physically or mentally, children regardless of age. The disability must have existed before the child turned age 26 or while the dependent child was a full-time student. A dependent child may be married* or unmarried and is not required to be a resident of the State of Iowa. * A dependent's spouse is not eligible for coverage.

When You Receive These Covered Services:	You Pay: Alliance Select	
	In-Network (Select Provider)	**Out-of-Network (Non-Select Provider)**
Office Visit Service	10% coinsurance after deductible	20% coinsurance after deductible
Specific Preventive Services – Includes one routine physical and related services (x-rays and lab work) per benefit period; mammogram; well-child care to age 7 including immunizations.	10% coinsurance after deductible	20% coinsurance after deductible
Immunizations	Not covered except for well child to age 7.	
Inpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Physician's office	10% coinsurance after deductible	20% coinsurance after deductible
Emergency room - Applies after OPM is met; waived if admitted	$100 copayment. 10% coinsurance after deductible	$100 copayment. 10% coinsurance* after deductible
Accident Care	10% coinsurance after deductible	20% coinsurance after deductible
X-Ray & Lab		
Inpatient	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office	10% coinsurance after deductible	20% coinsurance after deductible
Chiropractic Care	10% coinsurance after deductible	20% coinsurance after deductible
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
Routine Eye Exam - One per member per year	10% coinsurance after deductible	20% coinsurance after deductible
Maternity		
Inpatient	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office	10% coinsurance after deductible	20% coinsurance after deductible

When You Receive These Covered Services:	You Pay:	
	Alliance Select	
	In-Network (Select Provider)	Out-of-Network (Non-Select Provider)
Mental Health/Chemical Dependency	**Inpatient:** 10% coinsurance after deductible **Outpatient:** 10% coinsurance after deductible **Office services:** 10% coinsurance after deductible	**Inpatient:** 20% coinsurance after deductible **Outpatient:** 20% coinsurance after deductible **Office services:** 20% coinsurance after deductible
Prescription Drugs	10% coinsurance after deductible	

*** Processed at in-network level if true emergency.**